PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2007-D41

PROVIDER -
Newport Bay Hospital
Newport Beach, California

Provider No.: 05-4135

vs.

INTERMEDIARY -
Mutual of Omaha Insurance Company

DATE OF HEARING -
January 13, 2006

Cost Reporting Period Ended -
April 30, 2001

CASE NO.: 04-0805

INDEX

ISSUE:

Whether the Intermediary's decision to deny the Provider's request for an adjustment/exception to its Tax Equity and Fiscal Responsibility Act (TEFRA) target amount was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND

This is a dispute over the amount of Medicare reimbursement due a health care provider.

The Medicare program provides health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with the program's administration. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due providers under Medicare law and interpretative guidelines published by CMS. See, 42 U.S.C. §1395h, 42 C.F.R. §§413.20(b) and 413.24(b).

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider, and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the date of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

From the program's inception until 1983, hospitals were reimbursed the lower of their reasonable costs or customary charges for services provided to Medicare beneficiaries. 42 U.S.C. §l395x(v)(1)(A) defines reasonable costs as "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." Congress ultimately amended the reasonable cost payment system because it was concerned that while being reimbursed the reasonable costs of covered services, providers had no incentive to provide services efficiently or otherwise limit their costs. Congress first modified the law by enacting 42 U.S.C. §1395ww(a), which established limits on operating costs and authorized the Secretary of DHHS ("Secretary") to establish prospective limits on the costs recognized as reasonable in furnishing patient care.

In 1982, Congress enacted the Tax Equity and Fiscal Responsibility Act (TEFRA), again modifying the reasonable cost reimbursement methodology in order to create incentives for providers to render services more efficiently and economically. TEFRA imposed a ceiling on the rate-of-increase of inpatient operating costs recoverable by a hospital. The

TEFRA ceiling amount, or target amount, is calculated based upon the allowable Medicare operating costs in a hospital's base year (net of certain other expenses including capital and medical education costs) divided by the number of Medicare discharges in that year. The TEFRA target amount is updated annually based on an inflation factor. If a provider incurs costs below the applicable TEFRA target amount in a given cost reporting year, it is entitled to reimbursement for its reasonable costs plus an additional incentive payment.

In 1983, Congress enacted the Social Security Amendments, P.L. No. 98-21, which created the Prospective Payment System (PPS) for hospital inpatient operating costs. After the implementation of PPS, only providers and units within providers exempt from PPS that continued to be paid under the reasonable cost system were subject to the TEFRA rate-of-increase limit.

Generally, the amount of program payment made to a hospital under TEFRA is based upon a comparison of the hospital's allowable net inpatient operating costs with its TEFRA ceiling.[1] If a hospital incurs costs below the ceiling, it is reimbursed its reasonable costs plus15 percent of the difference between its inpatient operating costs and the ceiling, or its reasonable costs plus 2 percent of the ceiling, whichever is less. (The 15 percent or 2 percent add-on is commonly referred to as the "incentive" or "bonus" payment). Conversely, if a hospital's inpatient operating costs are greater than the ceiling, but less than 110 percent of its ceiling, reimbursement is limited to the ceiling. If a hospital's inpatient operating costs are greater than 110 percent of its ceiling, it is reimbursed the ceiling plus 50 percent of its allowable net inpatient operating costs in excess of 110 percent of the ceiling, or the ceiling plus 10 percent, whichever is less. 42 C.F.R. §413.40(d)(2) and (3).

Because the TEFRA ceiling is an upper limit, a provider may generally not be reimbursed for costs above the ceiling payment determination in any particular cost reporting period. However, implementing regulations at 42 C.F.R. §413.40(e) - (g) establish procedures by which providers may request and receive an adjustment to their TEFRA ceiling for reasons such as unusual costs due to extraordinary circumstances beyond the hospital's control (e.g., strikes, fire, earthquakes). In order for a hospital to receive an adjustment to its TEFRA ceiling, its request must be received by the intermediary no later than 180 days after the date on the intermediary's initial notice of program reimbursement for the cost reporting period at issue. 42 C.F.R. §413.40(e)(1).

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[1] The ceiling is the aggregate upper limit on the amount of a hospital's net Medicare inpatient operating costs that the program will recognize for payment purposes. For each cost reporting period, the ceiling is determined by multiplying the updated target amount, as defined in this paragraph, for that period by the number of Medicare discharges during that period. 42 C.F.R. §413.40(a)(3).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Newport Bay Hospital (Provider) is a 34-bed, short-term gero-psychiatric hospital located in Newport Beach, California. As a psychiatric hospital, the Provider is exempt from PPS and is reimbursed on the basis of reasonable cost subject to TEFRA's rate-of-increase ceiling. Mutual of Omaha Insurance Company (Intermediary) reviewed the Provider's cost report for its fiscal year ended April 30, 2001 and made an adjustment updating the Provider's TEFRA target amount pursuant to 42 U.S.C. §1395ww(b)(3)(A)(ii), 42 C.F.R. §413.40(c)(4)(ii). However, the Provider believed it was also entitled to have its target amount increased in accordance with 42 C.F.R. §413.40(e) - (g) due to the higher costs it incurred to serve a patient population comprised largely of geriatric patients with complex issues. The Provider made a claim for a higher TEFRA target amount as a "protested amount" on its as-filed cost report.[2] The Provider also claims that its initial request for a Board hearing dated February 12, 2004 constituted a request to adjust the TEFRA target rate. In addition, on June 28, 2004 and October 11, 2004, the Provider submitted to the Board its Preliminary and Final Position papers, respectively, alleging that these submissions effectively comprise a comprehensive TEFRA exception request. The Intermediary denied the Provider's request, concluding that the Provider's June 28, 2004 submission was the only affirmative exception request filed by the Provider. The request was, therefore, not timely filed within 180 days of the date of the NPR (dated August 20, 2003) as required by 42 C.F.R. §413.40(e)(1). [3]

The Provider appealed the Intermediary's adjustment to its TEFRA target amount to the Board on February 12, 2004 and asserted that the amount of Medicare funds in controversy was approximately $164,000.[4]

The Provider was represented by Mark S. Kennedy, Esq., of Kennedy Attorneys & Counselors at Law. The Intermediary was represented by Byron Lamprecht, Senior Appeals Consultant, Mutual of Omaha Insurance Company.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of Medicare law and guidelines, parties' contentions, and evidence presented, the Board finds that it lacks jurisdiction to decide the Provider's case. The Provider does not meet the "amount in controversy" requirement for a Board hearing. 42 C.F.R. §§405.1835 provides the criteria a provider must meet in order to have its case brought before the Board. In part, the regulation states that the amount in controversy must be at least $10,000. As noted above, the Provider determined that the adjustment to its TEFRA target amount which it believes appropriate would result in additional Medicare reimbursement due the Provider of approximately $164,000. However, the Provider's calculation is based upon an adjustment to its TEFRA ceiling (and a corresponding increase to its TEFRA incentive or bonus payment), not how much

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[2] See, Provider Exhibit P-7 ("Tab 7").

[3] Intermediary Post-Hearing Brief at 4-5.

[4] Provider's Post-Hearing Brief at 2.

additional reimbursement will be due to the Provider, which is inconsistent with program rules.

42 C.F.R. §413.40(g)(1)(iii) states: "[w]hen the hospital requests an adjustment, HCFA makes an adjustment only if the hospital's operating costs exceed the rate-of-increase ceiling imposed under this section." As shown in the Provider's own TEFRA Relief calculation and on Worksheet D-1, Part II of its final settled cost report (Exhibits P-1 and P-2, respectively), the Provider's net allowable inpatient operating costs are clearly below its existing or current TEFRA ceiling for the subject cost reporting period.[5] Therefore, the Provider's TEFRA ceiling is not subject to adjustment, the Provider's amount in controversy calculation is inaccurate, and there is no Medicare reimbursement at issue.

DECISION AND ORDER:

The Provider's appeal is dismissed. The Provider did not meet the amount in controversy criterion required for a Board hearing.

Board Members Participating:

Gary B. Blodgett, D.D.S
Elaine Crews Powell, C.P.A
Anjali Mulchandani-West
Yvette C. Hayes

Not Participating – Recused:

Suzanne Cochran, Esq.

FOR THE BOARD:

Date: June 8, 2007

Gary B. Blodgett, D.D.S.
Acting Chairman

[5] Each exhibit shows that the Provider received an incentive payment of $32,081, clearly indicating that its operating costs were less than its TEFRA ceiling.